EXHIBIT B

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TENNESSEE

DANIEL LOVELACE AND HELEN LOVELACE, INDIVIDUALLY AND AS PARENTS OF BRETT LOVELACE, DECEASED,

Plaintiffs,

VS. 2:13-CV-02289-SHL

PEDIATRIC ANESTHESIOLOGIST, P. A. BABU RAO PAIDIPALLI, AND MARK P. CLEMONS,

Defendants.

DEPOSITION

OF

MARK CLEMONS, M.D

February 6, 2014

MID-SOUTH REPORTING
Pepper Glenn, CCR
P. O. Box 609
Southaven, Mississippi 38671
(901) 525-1022

APPEARANCES

FOR THE PLAINTIFF:

Mark Ledbetter, Esq.
Halliburton & Ledbetter
254 Court Avenue
Memphis, Tennessee 38103
Phone: (901) 523-8153

FOR THE DEFENDANT:

J. Kimbrough Johnson, Esq.
Marcy Dodds Magee, Esq.
Thomason Hendrix, et al
2900 One Commerce Square
Memphis, TN 38103
901-525-8721

Brad Gilmore, Esq.
The Hardison Law Firm
119 S. Main Street
Suite 300
Memphis, TN 38103
901-525-8776

COURT REPORTING FIRM:

MID-SOUTH REPORTING
Pepper Glenn, CCR
P. O. Box 609
Southaven, Mississippi 38671
(901) 525-1022

The deposition of MARK CLEMONS, M.D. is taken on this 02/06/2014, on behalf of the Plaintiffs, pursuant to notice and consent of counsel, beginning at approximately 10:00 a.m. in the law offices of Thomason, Hendrix, Harvey, Johnson & Mitchell.

This deposition is taken pursuant to the terms and provisions of the Tennessee Rules of Civil Procedure.

All forms and formalities, including the signature of the witness, are waived, and objections alone as to matters of competency, irrelevancy and immateriality of the testimony are reserved to be presented and disposed of at or before the hearing.

INDEX

WITNESS: MARK CLEMONS, M.D.

VIDEO SPECIALIST: This is the video deposition of Dr. Mark Clemons. This is February 6, 2014. We are on the record at 10:17.

Counsel, would each of you please state your appearances for the record which will then be followed by the swearing in of the witness by the court reporter.

10:27:04 MR. LEDBETTER: Mark Ledbetter, counsel for Plaintiffs.

MR. JOHNSON: Kim Johnson for Dr. Clemons.

MS. MAGEE: Marcie Magee for

10:27:11 Dr. Clemons.

MR. GILMORE: Brad Gilmore for Dr. Paidipalli and Pediatric Anesthesiologists.

MARK CLEMONS,

called as a witness, having been first duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. LEDBETTER:

Q. Dr. Clemons, I'm Mark Ledbetter and

we've previously met. And I have passed to you and to your counsel three items which I've proposed to make exhibits to your deposition. The first item is the anesthesia medication

10:27:40 record. And do you have that before you?

A. **Yes.**

(WHEREUPON, THE ABOVE-MENTIONED DOCUMENT WAS MARKED AS EXHIBIT NO. 1 TO THE TESTIMONY OF THE WITNESS AND

10:27:43 IS ATTACHED HERETO.)

Q. Okay. Is that a document you have previously seen or you're familiar with?

A. **No.**

Q. Okay. Do you have any reason to

10:27:52 believe that that record is inaccurate or does not apply to this patient?

A. **I do not give any of these drugs. I'm not an anesthesiologist. I've never seen this record before.**

10:28:02 **Q.** Okay. Number 2, this is a history of current problems for the patient. And do you identify that as a document that you've created?

A. **That is my document.**

(WHEREUPON, THE ABOVE-MENTIONED

DOCUMENT WAS MARKED AS EXHIBIT NO. 2 TO THE TESTIMONY OF THE WITNESS AND IS ATTACHED HERETO.)

Q. Okay. And beneath it, you will see

10:28:17 that there are several pages that purport to be an op note or an operatory narrative that you also wrote.

A. **Yes, I did.**

Q. Okay. And Exhibit Number 3 is a

10:28:33 series of photographs that I will represent to you were taken by the parents of Brett Lovelace. And let me ask if you can identify any of the people in the photograph -- in the photograph particularly on the first page. Can you identify

10:28:49 that as Brett Lovelace?

A. **That is Brett Lovelace.**

(WHEREUPON, THE ABOVE-MENTIONED DOCUMENT WAS MARKED AS EXHIBIT NO. 3 TO THE TESTIMONY OF THE WITNESS AND

10:29:03 IS ATTACHED HERETO.)

Q. Could you identify who is in the left corner?

A. **Do not know.**

Q. Could that be his father, Daniel

Lovelace?

A. **Might be, but I do not know.**

Q. Okay. On the second page, who do you see on the top left of the top photograph on the

10:29:11 second page?

A. **I believe that's the nurse anesthetist.**

Q. Okay. That would be Grace Freeman?

A. **Yes.**

10:29:19 **Q.** Okay. And below that, do you note who the blonde lady is in the picture on Page 2?

A. **One of the pre-op nurses.**

Q. Okay.

A. **I do not know her name.**

10:29:28 **Q.** Would that be her in the -- on the Page 3?

A. **Yes.**

Q. Okay. And on Page 4, would that be her on the top of Page 4 with Brett Lovelace?

10:29:40 **A.** **Appears to be.**

Q. Okay. And the bottom picture on Page 4, is that Dr. Paidipalli?

A. **Looking at the bottom of the page where you have -- no clue who that is.**

Q. Okay, and on Page 5, who is that?
A. **That is Dr. Paidipalli.**
Q. Paidipalli. And on the next page, who is that in the top photograph with Brett?
A. **I think that is Dr. Paidipalli.**
Q. Okay. And on the bottom of page -- of that page, who is it?
A. **That's me.**
Q. Okay. And on the next page, is that you also in the top and bottom photograph?
A. **That is still me.**
Q. And on the last page, is that still you with --
A. **Still me.**
Q. Okay. And then on the next page, it's the nurse with him, correct?
A. **Correct.**
Q. And on the last page, you see two photographs. What is going on there or can you tell?
A. **Top one, he is yawning. The bottom one, I do not know.**
Q. Okay. But you don't know the timing or the sequence of it?

A. **I don't understand what the question is.**
Q. Okay. All right, sir. Now, prior to today's deposition, Dr. Clemons, have you ever been an expert witness in a malpractice case?
A. **No.**
Q. Have you ever testified either for a Plaintiff against a doctor or in favor of a doctor in a malpractice case?
A. **No.**
Q. Have you ever consulted for a Plaintiff or for a Defendant in a malpractice case?
A. **I reviewed a record or two, but that's about it.**
Q. Okay. Now, let me just ask you a general question about the practice of medicine. Do you agree that a lack of knowledge in a doctor could be dangerous in the medical field?
A. **Medicine is an ongoing learning process. Every day you learn a little something new and you use it.**
Q. But do you agree that lack of knowledge as a part of your fund of information

can be dangerous as you go about your daily practice? Is that a good general rule that you would agree with?
A. **There is always something that you don't know.**
Q. Okay. Well, then, do you approve of a lack of knowledge among medical practitioners or do you think that medical practitioners should yearn and seek to improve and increase their knowledge?
A. **Everyone should work to improve their knowledge.**
Q. Okay. Do you think a lack of knowledge is dangerous in the medical field?
A. **We always strive to learn more, to know more.**
Q. Okay. I understand that, but can you answer my question as it is posited to you? Why is a lack of knowledge dangerous or is a lack of knowledge dangerous in the medical field?
A. **A lack of knowledge, it sounds like a Rumsfeld question. We always need to know more even under the best of circumstances. Information you don't have is always important**

and so sometimes, you don't have everything you would like and that can be a problem.
Q. Well, let me ask you maybe a general kind of question that may move you a little further with this. In this case, would the lack of knowledge of some vital statistics about Brett Lovelace have been dangerous such as his weight, 81 kilograms or 180 --
A. **We knew his weight.**
Q. Excuse me?
A. **We knew his -- we knew he was overweight.**
Q. Okay. But would a lack of knowledge of that have been dangerous in his case perhaps?
A. **What is your question? You're giving me a hypothetical.**
Q. I am giving you a hypothetical, but you have to answer questions that are posited to you that are fair. Would a lack of knowledge of the patient's weight have been dangerous? You said you had that knowledge. My question is simply whether a lack of it would have been dangerous.
A. **Sometimes lack of knowledge is**

important and you are missing it, and it is important.

Q. Okay. Do you agree that weight is important to know for a patient like Brett?

A. Weight is always important to know.

Q. Okay. All right. And would you agree that if you had lacked knowledge of his asthma, his snoring, apnea, mouth breathing, if you had lacked knowledge of those things, that could have been dangerous in his case, could it not have?

A. We knew this.

Q. So I'm asking you had you not known that, could that have been dangerous to his health and safety?

A. But we knew this.

Q. I understand you knew that, but you're not answering my question. I'm the examiner, not you. You're not entitled to ask yourself questions you want. Do you understand that?

MR. JOHNSON: Well, you ask him questions and then let him answer.

MR. LEDBETTER: He's not answering them.

MR. JOHNSON: Well, he's

answering them because you've asked him something that he said he already has -- or he knows.

BY MR. LEDBETTER:

Q. Okay. Would the lack of knowledge of these -- this history have been dangerous in Brett's case?

MR. JOHNSON: Let me ask you, lack of knowledge by whom?

MR. LEDBETTER: By the surgeon or the practitioners involved.

BY MR. LEDBETTER:

Q. Would that have been dangerous had they lacked that information?

MR. JOHNSON: Objection.

MR. GILMORE: Object to the form.

MR. JOHNSON: Objection.

BY MR. LEDBETTER:

Q. They have objected to the form. Is it your testimony --

A. For this particular case --

Q. Yes.

A. This is all important information that

one should have. If you didn't have it, it would be a problem.

Q. Okay. Thank you. Now, had you previously worked or performed surgery with Dr. Paidipalli?

A. I have operated with Dr. Paidipalli many times.

Q. Before this incident, how many times had you worked with him in surgery?

A. Can't count --

Q. Just do your best.

A. I have been operating at LeBonheur for almost 20 years. You know, if I said 100, I could be off by 100. I have operated with the man many, many times.

Q. Okay. And had you worked with Grace Freeman on many occasions prior to this episode?

A. Several. More than five, best I can tell you.

Q. Were they social acquaintances of yours or people that you saw outside the context of LeBonheur?

A. I only work with them. Did not know them otherwise.

Q. Okay. All right. Now -- so would it say -- be fair to say that at the time of this procedure, you had a certain level of comfort or trust with Dr. Paidipalli and the CRNA, Grace Freeman?

A. Yes, it was a team.

Q. Okay. And now, before the surgery on March 12, 2012, Dr. Clemons, did you meet with Dr. Paidipalli or Grace Freeman, the nurse anesthetist, to discuss the anesthesia plan?

A. No.

Q. Did you meet with them prior to the surgery to discuss the patient's medical history?

A. No.

Q. Okay. Were you aware prior to today the specific medications that are listed on Exhibit 1 that I provided to you and your counsel that were used to facilitate the induction or the anesthesia for this patient? Were you aware of these medications?

A. Anesthesia chooses the drugs they want to use according to their needs -- according to the patient's needs. I may ask periodically what they have given just for my own knowledge, but

no, I'm not aware of these -- actually what they use on any given case.

Q. Okay. So would it be fair to say that prior to 3-12-2012, you did not routinely have discussions with Dr. Paidipalli in prior meetings about what his anesthesia medication record would be?

A. **Correct.**

Q. Okay. All right. Now, did you have any knowledge on March 12, 2012 of the prior claims against Dr. Paidipalli that have been raised or made for prior malpractice cases?

A. **No knowledge of any.**

Q. So in summary, before the operation on Brett Lovelace, Dr. Clemons, you did not have a knowledge of what his planned approach or medications would be with your patient, Brett Lovelace. You agree?

A. **No. And normally, I don't.**

Q. Okay. And as we sit here, you did not know what drugs or dosages he used and the rationale for it for the anesthesia, do you?

A. **He gives -- he decides what the drugs are. He knows these drugs. I do not.**

Q. Okay. Now, at the time of Brett Lovelace's T&A, which I guess -- may I use that as a term?

A. **Sure.**

Q. Okay. This T&A, did you approve of the joint use of Propofol and Fentanyl?

A. **I had -- I don't tell anesthesia what drugs to use.**

Q. So the answer, then, is that you did not approve or disapprove of the use of Propofol or Fentanyl?

A. **Correct. But I did not know what drugs they were going to use either.**

Q. Dr. Clemons, were you aware on 3-12-2012 of the interaction of these drugs if given conjointly?

A. **Which drugs are we talking about?**

Q. Talking about Propofol and Fentanyl.

A. **Historically, I think they have been used together many, many times.**

Q. Were you aware of the interaction of the drugs? In other words, what synergy or what they --

A. **Which interaction are we talking**

about?

Q. We're talking about any interaction that the two drugs have, how one affects the other, whether it exaggerates it or whether it minimizes it.

A. **This is an anesthesia pharmacology question. I don't know.**

Q. All right. You agree, then, you did not know at the time of Brett Lovelace's surgery what drugs were to be given by Dr. Paidipalli or how they interacted and might or could adversely affect Brett Lovelace?

A. **I have no knowledge of any of that.**

Q. Now, how many surgeries did you perform on average in 2012 at LeBonheur?

A. **Probably about 200.**

Q. Did you have other surgeries scheduled on 3-12 of 2012 besides this surgery?

A. **I don't believe so.**

Q. Okay.

A. **You know, I just don't know if I did a case. I probably may have done a case or two beforehand.**

Q. Okay. All right. Now, I asked you

about the drug Propofol. Do you know what the drug Propofol is, whether it's an anesthetic or an analgesic, or what it is?

A. **It's a drug used for general anesthesia.**

Q. And with respect to Fentanyl, do you know what class it is or what kind of drug it is?

A. **It's a rapid acting narcotic.**

Q. Okay. Are you aware that Fentanyl was and is an opiate that has 150 times the potency of morphine?

A. **It is significantly more potent than morphine.**

Q. Okay. Now, were you aware that Propofol and Fentanyl interact and that the combination delays recovery from anesthesia?

A. **Well, both are used for general anesthesia, so certainly, they would both affect general anesthesia.**

Q. My question was, were you aware that the combination delayed a recovery from anesthesia?

MR. GILMORE: Same objection.

A. **No.**

BY MR. LEDBETTER:

Q. Were you aware that Fentanyl causes rigidity to the muscles of respiration?

A. **No.**

Q. So it's true that you lack the knowledge of it's use in this case, as well as the fact that it is hampering respiration?

A. **Anesthesia decided what to use. I do not know whether he used it or not.**

10:43:41 Q. Were you aware as a surgeon performing this T&A that Fentanyl leaves respiratory -- leaves a respiratory depressant effect which is evident for three to four hours?

A. **No, I did not.**

10:43:59 Q. Had Dr. Paidipalli ever discussed or tell you that?

A. **Over the years, we've never had that kind of discussion.**

Q. Were you aware as a surgeon in this

10:44:11 case that even a minor degree of airway obstruction could be hazardous to a patient given Fentanyl to put them to sleep?

MR. GILMORE: Object to the form.

A. **Fentanyl is -- Fentanyl is commonly used on people for general anesthesia. The Propofol is commonly used for ENT cases because it wears off so quickly. Lots of people like**

10:44:48 **Propofol because it's rapidly -- metabolized and rapidly gone. So the use of them together is not -- my sense is it's not uncommon, but not being an anesthesiologist, I couldn't tell you how common.**

10:45:00 BY MR. LEDBETTER:

Q. Okay. Were you aware that a minor degree of airway obstruction in a patient who's undergoing surgery could be hazardous to a patient who was given Fentanyl?

10:45:15 A. **All narcotics can cause some --**

Q. Would your answer --

A. **-- increase of respiration.**

Q. Would your answer then be yes, that you were aware that a minor degree of airway

10:45:25 obstruction could be hazardous with a patient given Fentanyl, an opiate?

A. **Airway obstruction after narcotics is always a concern.**

Q. Were you aware at the time of Brett

Lovelace's surgery on March 12, 2012 that airway compromise is the major cause of death or major injury in claims that arise after a tonsillectomy?

10:45:57 A. **I did not know that.**

Q. Were you aware that Fentanyl is specifically contraindicated where there is upper airway obstruction?

MR. GILMORE: Object to the

10:46:11 form.

A. **I did not know that.**

BY MR. LEDBETTER:

Q. Were you aware of that?

A. No.

10:46:14 Q. Were you aware that Fentanyl is contraindicated where there is asthma?

MR. GILMORE: Object to the form.

A. **I did not know that.**

10:46:22 BY MR. LEDBETTER:

Q. Were you aware that Fentanyl itself can cause slow, shallow respiration and apnea?

MR. GILMORE: Object to the form.

A. **All narcotics probably can do that.**

BY MR. LEDBETTER:

Q. Were you aware that Fentanyl specifically could?

10:46:43 A. No.

Q. Were you aware that a dose of BIMU-8 or Narcan were fast acting antidotes to any Fentanyl respiratory suppression?

A. **I don't understand what the question**

10:46:58 **was.**

Q. Are you familiar with BIMU-8 or Narcan?

A. **Narcan, yes.**

Q. Were you aware that if there is a

10:47:08 respiratory suppression by Fentanyl, that that is an antidote, that Narcan --

A. **Narcan is an antidote for narcotics, correct.**

Q. Do you agree that it would have been

10:47:19 Dr. Paidipalli's choice to use the Fentanyl and the Propofol, not yours? That was his choice.

A. **That would have been his choice.**

Q. Okay. Now, before the 3-12-2012 T&A procedure that you performed on Brett Lovelace,

did you ever look at the Physicians' Desk Reference to study Fentanyl's warnings?

A. No, as I don't give Fentanyl.

Q. Did you, on March 12, 2012, know that there were specific warnings about respiratory suppression, an alteration in the respiratory rate of patients given the drugs?

A. No, I did not know this.

Q. So you lack knowledge of the FDA approved warnings that applied to these drugs that were given to Brett Lovelace by Dr. Paidipalli?

A. Correct.

Q. Now, when Brett Lovelace reached the recovery room -- which I'm going to call PACU or I may call it recovery.

A. We prefer recovery room, too.

Q. Okay. It's interchangeable. He was not -- this is a question, not an answer. He was not on supplemental oxygen at that time, was he?

A. My experience at LeBonheur is everybody leaving the operating room is on supplemental oxygen.

Q. Do you recall him --

A. But they went to recovery room and I went to change my clothes, so I don't know.

Q. Okay. Now, when he reached the recovery room, did you give a doctor's order that he was to remain on supplemental oxygen to Nurse Kish or whoever would have been the nurse attending?

A. Generally speaking, anesthesia orders in the recovery room will say they should be on oxygen to keep their saturation up above 90 to 92 percent.

Q. Okay. Did you, at any time, specify that the PACU continue supplemental oxygen for him? Did you?

A. I don't believe so.

Q. Okay. Did you -- when you went to the recovery room or PACU, did you visit with Grace Freeman or see Grace Freeman there?

A. I don't remember.

Q. Okay. Now, I have asked this same question earlier, but I'm going to ask it again, so I'm just warning you. But were you aware that Fentanyl suppressed respiration and for a patient with any upper airway or breathing problems,

there was a risk of delayed respiratory suppression?

MR. GILMORE: Object to the form.

BY MR. LEDBETTER:

Q. Were you aware of that risk of delayed respiratory suppression?

A. No, but that's why we have recovery rooms, so the patient can be watched.

Q. Okay. So you agree that when Brett Lovelace was anesthetized, you and Dr. Paidipalli had no discussion about his asthma, did you? Did you have any discussion with Dr. Paidipalli about the asthma?

A. No, but he knew he had asthma and I knew he had asthma.

Q. Did you have any discussion with him about his sleep-deprived breathing in his medical history?

A. No, but according to -- his history would have picked up and my history picked that up. That's why we do tonsillectomy and adenoidectomy.

Q. Did you have a discussion with

Dr. Paidipalli about his apnea?

A. No. I don't believe the mother ever talked to me about apnea either.

Q. Did you have any discussion with Dr. Paidipalli about his snoring and mouth breathing?

A. No, but all these kids with big tonsils and adenoids have snoring and mouth breathing. There would never have been a need to discuss this.

Q. And in your note of his history, you say his tonsils are enlarged three plus. What does that mean?

A. Means they are very large, but they are not quite touching.

Q. Okay.

A. It's a relative size.

Q. I understand. Now, again, you had no discussion with Dr. Paidipalli about the potent opiate Fentanyl and any effect it might have on Brett's breathing, did you?

A. No.

Q. Did Dr. Paidipalli ever solicit your opinion on how to put Brett Lovelace to sleep and

29

keep him safe?
A. The anesthesiologist never ask the ENT doc how to do his own job.
Q. Did you ever ask Grace Freeman or Dr. Paidipalli about what drugs they planned to use?
A. No.
Q. Now, when you went to the recovery room, you did not see Dr. Paidipalli there, did you?
A. I don't think so.
Q. Best of your knowledge, he did not accompany the patient to the recovery room, did he?
A. I don't know. I went one direction. They went another direction.
Q. Have you ever seen Dr. Paidipalli, in these many procedures that you've had with him, go with the patient to the recovery room? Have you ever seen him do that?
A. Yes.
Q. Okay. Most of the time or half the time? How many times?
MR. GILMORE: Object to the

30

form.
A. I have no idea. I mean, this is a routine thing that happens every day. It's sort of like background noise.
BY MR. LEDBETTER:
Q. Would you say it was common for him to go to the recovery room in cases that you've had with him or uncommon?
A. It's a mixed bag. Sometimes he goes. Sometimes he doesn't.
Q. Now, are you familiar with the Glasgow Coma Scale?
A. I've heard of it, but I really don't -- I really don't know how its evaluation is.
Q. Can you give us any assessment using the Glasgow Coma Scale for Brett Lovelace when he was extubated?
A. I can't do anything about the Glasgow Coma Scale except I have heard about it.
Q. It would be fair to say that when he arrived in the recovery room or PACU, you could not give us a Glasgow Coma Scale rating for him there either?

31

A. I cannot give it to you because I don't know what the numbers are in the coma scale.
Q. Now, you have -- in Exhibit Number 2 after the first page, Dr. Clemons, you have your op note or your operative report.
A. Correct.
Q. Do you see that?
A. Correct.
Q. Okay. Now, do you know when this was written? I see that the date of service was March 12th, but the date it was signed was March 19th. Do you know when this was written by you or dictated?
A. It probably would have been that day or the next day, the day after surgery. Transcription could tell you that. I don't know.
Q. I think I see it. Turn to the last page and let me ask you --
A. Dictated.
Q. Yeah, it's a D. Does that mean that it was dictated March 12 at 5:48 p.m. or when, 5:48 a.m.?
A. It certainly wasn't 5:48 a.m.

32

Q. Well, is that what it shows, is that you dictated it before the surgery?
A. No. I would never dictate anything before a surgery.
Q. Okay. But I'm saying is that what the record shows?
A. I don't know. I can barely tell what it says.
Q. It says D 03-12-12. That would be the correct date of the surgery.
A. Right.
Q. And then it says 0548, and that would be 5:00 a.m., would it not?
A. True. But more likely, it was dictated at 5:00 p.m.
Q. But 5:00 p.m. would be 1748, would it not?
A. Correct.
Q. And it shows that it's transcribed at what, 6:10 a.m.?
A. Right.
Q. Okay. Who is SC?
A. Person transcribing it, I guess.
Q. Okay. So the record itself shows that

it was -- it was dictated before -- dictated and transcribed before the surgery; is that correct?

A. That's what it says, but it wasn't.

Q. All right. Now, did you ever go back after it was dictated and make any changes to it before it was made a permanent record?

A. Not that I know of, but I'm sure I read it and might have changed a "we" to a -- I change words like "we" to "I," but I couldn't 10:57:36 **tell you if I changed a word or two.**

Q. Well, do you think on the last page, you might have changed the word -- the last sentence from reading, "He tolerated the procedure without problems" to read "He tolerated 10:57:48 the procedure itself without problems"? Could you have made that change by adding the word "itself" after he died or after he had problems?

A. Well, when I talk about the procedure, I'm talking about the operative procedure.

10:57:59 Q. Right.

A. We did the surgery. We woke him up, extubated him and took him to the recovery room.

Q. Well, my point is, where it says he tolerated the procedure itself, do you think

after he coded, that you might have added the word "itself" or do you think that would have occurred maybe in a later revision, or do you know?

10:58:21 **A. I'm not as smart as you to think about that one.**

Q. Now, in your note -- in your note about the procedure, you agree that if you dictated this at 5:48 in the morning, you 10:58:40 certainly couldn't predict the outcome of the surgery and how well he did in it, could you?

A. I wasn't up at 5:48 that morning, so it couldn't have been dictated at 5:48 that morning.

10:58:50 Q. Then you would agree that it couldn't have been dictated -- it couldn't have been correct if it was dictated then, right?

A. It wasn't dictated then.

Q. Okay. Now, did you have a 10:59:07 conversation with Brett when he was in the operating room and when he was extubated? Did you visit with him? Did he respond to you verbally?

A. When Brett woke up -- teenagers are

likely to do this -- he started trying to climb off the operating table. But -- so people were there to keep him from falling off the table, hurting himself. And this is common with 10:59:35 **teenagers. And so we got him calmed down and he woke up a little more and was breathing on his own. They moved him to the stretcher and then took him to the recovery room. At that point, nobody is having a conversation with the patient.**

10:59:50 Q. All right. At that point, did you do any sort of -- you've said previously you didn't know how to do an assessment under the Glasgow Coma Scale. Did you do any sort of assessment of him using either the modified Aldrete or the 11:00:09 Aldrete scale to determine his motor activity or his mental activity or his physical activity relative to pain? Did you do any assessment like that?

A. Up until reading these reports, I had 11:00:24 **never seen that second scale. And I'm in the room. If there is an airway issue, I try and stay in the room if there is an airway issue when they extubate them. And they got the young man extubated. He was breathing on his own at that**

point. I personally did not do an assessment beyond that.

Q. Did you observe him being connected to supplemental oxygen after the extubation? Do you 11:00:53 remember seeing that happen?

A. Routinely, that happens on these kids and it's like I said before, this is like background noise. They do it routinely and you don't pay attention to it.

11:01:07 Q. Okay. Would it be fair to say that you do not specifically recall in this instance the moment that that did or did not occur?

A. Correct.

Q. Okay. Now, when he was extubated, do 11:01:30 you recall whether Brett Lovelace obeyed commands, like look at me or nod?

A. I do not know.

Q. Is there usually a test that you give a patient when they have been extubated?

11:01:45 **A. Well, there are two ways to extubate people. One is deep and one is awake. On little bitty kids without significant airway problems, they like to do it deep. On older -- on people with airway problems, you like to do more awake**

where they can follow commands. Follow commands doesn't mean you and I are having a conversation. It's more of, you know, raise your hand, open your eyes, you know, something that says yes, the person's awake enough that we could move to the next step.

Q. Okay. But would you say that -- which sort of extubation was this? Was it deep or what?

11:02:25 MR. GILMORE: Object to the form.

BY MR. LEDBETTER:

Q. How would you characterize his extubation?

11:02:31 MR. GILMORE: Same objection.

A. Not being the anesthesiologist or the person giving the instructions at that moment, I couldn't tell you which one they actually did.

BY MR. LEDBETTER:

11:02:44 Q. Do you agree that you do not have a test that you administer to your patients in the OR when they are extubated to satisfy yourself about their level of consciousness?

A. I'm not the person doing this.

Q. Okay. Now, do you agree as we are sitting here, that when he was extubated and upon his arrival in the PACU, did you ever see Brett Lovelace's face when he was in the PACU or was

11:03:24 his face concealed from view?

A. When I got into the recovery room, Brett had rolled over onto his stomach.

Q. So you did not, at that point, see his face or observe supplemental oxygen on him?

11:03:42 A. I don't believe so.

Q. Okay. Now, were you aware on 3-12-2012 or today that children who are at risk for sleep apnea or obstructed sleep apnea should not receive more than a half dose of an opiate

11:04:06 such as Fentanyl because of the respiratory depressant effect of the drug?

MR. GILMORE: Object to the form.

A. As stated before, I'm not conversant

11:04:21 with Fentanyl other than knowing that it's a narcotic. It's rapid acting compared to others, it wears off faster.

BY MR. LEDBETTER:

Q. But you were not aware that it had a

three to four-hour attenuated respiratory suppressant or depressant effect?

A. No.

Q. Now, had you, prior to today, ever

11:04:47 read any medical articles that state that if a patient has upper airway surgery, has obstructions or apnea, that they should be directed to the ICU for recovery under a doctor's care instead of to the PACU or nursing assistance

11:05:07 only?

A. There is all sorts of literature you can find. Kids and adults every day have tonsillectomy and adenoidectomy for upper airway obstruction and sleep apnea. In kids, generally

11:05:20 speaking, that is the treatment for sleep apnea. The first thing that you would want to do is get them awake. It's extremely rare you would send someone straight to the ICU unless you had them on a ventilator.

11:05:33 Q. Okay. Well, I mean, if they are on supplemental oxygen --

A. Everyone is on supplemental oxygen in the recovery room when they get there.

Q. Excuse me?

A. Almost everyone is on supplemental oxygen for a short while in the recovery room when they get there.

Q. But you never saw Brett on

11:06:04 supplemental oxygen in the PACU, did you? You said you didn't

A. In absolute terms, I couldn't tell you.

Q. And whose prerogative would it have

11:06:06 been, yours or Dr. Paidipalli's or both of you jointly, to opt for ICU for Brett Lovelace instead of the PACU? Whose call was that?

A. Well, if a patient -- okay. In real terms, patient is having immediate problems in

11:06:32 the operating room and you thought that you really needed the ICU. You might send them straight -- you might try and get them straight to the ICU. But in the real world here, postop tonsillectomy, adenoidectomy in a healthy child

11:06:42 or adult even, you would go to the recovery room. And then if you were having problems, then you decide to either admit them or go to the ICU.

Q. Okay. The question I asked was not directly answered and it is, was it your

prerogative or would have it have been Dr. Paidipalli's prerogative or a joint prerogative to have had Brett dispatched to the ICU?

MR. JOHNSON: At what time? At what time?

A. At what time? When?

MR. JOHNSON: At what time? When?

11:07:16 **A. When?**

BY MR. LEDBETTER:

Q. After surgery.

MR. JOHNSON: When after surgery?

A. In the operating room or in the recovery room or where?

BY MR. LEDBETTER:

Q. Did you hear my question? I said after surgery.

11:07:24 MR. JOHNSON: And he's asking you --

A. It's always my prerogative to admit someone after surgery.

BY MR. LEDBETTER:

Q. Okay. That's the question I asked. Now, you're aware that he ended up in the ICU after he coded, correct?

A. Correct.

11:07:37 **Q.** Did you know Dr. Bugnitz who was in the ICU?

A. Never met him before.

Q. Never met him before.

Okay. Have you had any sort of

11:07:47 discussion with him since 3-12-2012?

A. We may have talked a little bit right after Brett was admitted, but that's -- beyond that, nothing.

Q. Okay. Now, can you tell me whether or

11:08:08 not in your opinion -- or tell me what the Sims' position is for a patient. Are you familiar with the term?

A. I don't know what the Sims' position is.

11:08:17 **Q.** Okay. Are you familiar with what the supine position is?

A. Supine.

MR. JOHNSON: Do you want to pronounce it right?

A. Supine.

BY MR. LEDBETTER:

Q. Okay. What is that position?

A. They are on their back.

11:08:31 **Q.** And what is a prone position?

A. On their belly.

Q. Do you know what the Fowler's position is?

A. Well, Semi-Fowler's is sort of a

11:08:46 **sitting, laying position. I don't know what the Fowler's position is.**

Q. Okay. Any reason why Brett was not in a Fowler's position?

MR. GILMORE: Object to the

11:08:54 form.

A. Well, what is a Fowler's position?

BY MR. LEDBETTER:

Q. I'm asking you if you know what it is.

A. I told you I don't know what a

11:08:58 **Fowler's position is. I know what Sub-Fowler's is.**

Q. But you don't know what the Fowler's position is?

A. No.

Q. Do you know what a lateral position is?

A. On their side.

Q. Okay. Is that -- would that have been

11:09:13 a proper position for Brett to have been -- been in, is on his side? Would that have been an effective --

A. Commonly.

MR. GILMORE: Object to the

11:09:20 form.

BY MR. LEDBETTER:

Q. Would that have been an effective position for him to have been in?

A. On the side would have been a good

11:09:30 **position.**

Q. All right. Now, at the time that you departed the PACU after Brett Lovelace's surgery, did you leave any orders for the attending nurse in the PACU to put him in a different position

11:09:48 such as a lateral position or a Fowler's position?

A. I don't routinely tell the nurse to put them in any particular position. The recovery room has its procedures to get people

awake and kids move around, but I had no -- I don't believe I had any orders for any particular position.

Q. Now, would you agree that the lateral position, which is also a Sims' position I'll reference, you would have been able to observe whether or not Brett Lovelace's airway was functional -- his upper airway was functional, could you not have?

11:11:00 A. What you would better observe is whether he was drooling or bleeding in the lateral position, whether he was breathing or not. I don't know that that would have helped you.

11:11:09 Q. Okay. Now, had you left him with orders for supplemental oxygen, that would also have been prudent if no one had, would it not have?

MR. JOHNSON: Objection.

11:11:24 A. My experience is they roll out of the operating room on oxygen whether I order it or not.

BY MR. LEDBETTER:

Q. But you did not verify that?

A. No, I don't believe so.

Q. Now, when it comes to doing this type of surgery, what is called a T&A, do you agree that it requires, between you and the

11:11:51 anesthesiologist, a high degree of cooperation because you are sharing airway?

A. We do share the airway.

Q. Okay. And you must jointly assure that oxygen is provided to the patient, agree?

11:12:08 A. Oxygen should be provided to the patient.

Q. And must jointly assure that carbon dioxide is eliminated?

A. If you're ventilating the patient,

11:12:21 oxygen is going in and carbon dioxide is going out.

Q. Okay. But you understand -- you agree that it's your joint goal to make sure that carbon dioxide is eliminated? In other words, it

11:12:36 isn't pooled so that they develop hypercapnia or --

A. Respire. Oxygen goes in and carbon dioxide goes out.

Q. And you must both assure that there is

adequate anesthesia, correct?

A. Anesthesiologist is giving the anesthesia. And if we get light -- which this didn't happen. If we get light, then they note

11:13:02 it and they give them more anesthesia.

Q. And you also must jointly see that there is a rapid return of consciousness and airway reflexes after the T&A. Do you agree?

MR. JOHNSON: Objection. I'm

11:13:16 going to ask you to be more specific about when after the surgery. It can be 24 hours, six days. I mean, when you're talking about after the surgery,

11:13:27 please be more precise about what it is that you are asking or when you are asking it.

MR. LEDBETTER: Okay.

BY MR. LEDBETTER:

11:13:35 Q. The question that I'm going to reask you will be with a view toward addressing Mr. Johnson's points.

Do you agree that following surgery, that it is crucial for the surgeon and the

anesthesiologist to assure a rapid return of consciousness as long as they are active and on task?

MR. JOHNSON: Objection.

11:14:07 MR. GILMORE: Object to the form.

BY MR. LEDBETTER:

Q. Do you agree with that?

A. During the operation, everyone has a

11:14:14 task. Okay. It's a team. Anesthesia puts them to sleep, surgeon does the surgery, anesthesia wakes them up and go to recovery room. Okay. We're not all doing the same thing at the same time.

11:14:29 So after doing that, we wake them up. The child is breathing. If the child is not breathing in the operating room, we put a breathing tube back down. Now, we go to recovery room. You go in the recovery room again to make

11:14:40 sure that they are awake. I went into -- so then, again, the tasks are flowing down.

The recovery room nurse is now watching the patient and the flow of information at that point comes from the recovery room nurse

49

when we -- after we leave.
Q. Do you agree with me that when you last parted company with Brett Lovelace, that he was not, quote, fully awake when you last saw him?
A. Right. He was not fully awake.
Q. Okay. And that prior to that time in the OR when he was extubated, he was not fully awake either?
11:15:20 A. No, not awake in the sense that we use -- the layman would use the term "awake."
Q. Okay. You never discussed sedative options with Dr. Paidipalli?
A. I don't tell him how to do his job.
11:15:46 Q. Did you know that it was wise to let sleep apnea patients remain in the ICU as a precaution to an airway issue?
A. Sleep apnea patients rarely go to the ICU.
11:15:59 Q. Really? You mean you rarely send them there?
A. In the 30 years I have been doing this, I can't remember one sleep apnea patient that we sent to the ICU who woke up -- who woke

50

up without any problems.
Q. How about asthma patients?
A. No.
Q. Asthma is an incurable disease. Do
11:16:33 you agree? It has no --
A. It's a chronic disease. It's a chronic disease.
Q. But it's not curable, is it?
A. Not to my knowledge.
11:16:39 Q. And do you agree that surgery can be an iatrogenic trigger for it? It can trigger asthma.
A. Much of the anesthesia they use actually will make the asthma component better,
11:16:58 at least while they are giving the particular drugs.
Q. Before this surgery when you saw him in the office on the 5th of March, I believe, or any time thereafter, did you perform any
11:17:12 spirometry on him or send him out to a third party for spirometry?
A. No, no, that's not routine.
Q. Now, were you aware on 3-12-2012 that in a group of 50 percent -- that in a group of

51

children with OSA, that -- who were given Fentanyl, 50 percent of the group developed complete apnea as a result of the use of Fentanyl?
11:17:45 MR. GILMORE: Objection to the form and foundation.
BY MR. LEDBETTER:
Q. Did you know that?
A. No.
11:17:51 Q. In the prescription for 200 milligrams of Fentanyl, if that had been -- that dosage had been halved, what would it have been?
A. Half of 200 is 100.
Q. Okay. And you weren't aware of any
11:18:13 medical literature that discussed having the Fentanyl dosage in patients who had a history of OSA?
A. No.
Q. Now, on March 12, 2012, Dr. Clemons,
11:18:41 did you follow any specific extubation criteria or were you aware of one that Dr. Paidipalli was following?
A. No. I leave it to the anesthesiologist to decide when to extubate the

52

patient.
Q. And do you agree that on March 12, 2012 that asthma, sleep-deprived breathing, obesity, hypertrophic tonsils and apnea were
11:19:05 among the medical history items that had been brought to your attention by Brett Lovelace's parents?
A. Correct.
Q. Now, do you agree that if he had been
11:19:14 extubated in a fully awake condition, once his airway was restored and had been kept in a Fowler's position or upright on supplemental oxygen, that it's unlikely that what happened here would have occurred?
11:19:40 A. Conjecture. Don't know.
Q. You don't know. Let me ask you this: Are you aware of the use of each of these different means? In other words, extubated and fully awake, are you aware -- do you know what
11:19:53 that means?
A. When they say extubated and awake, that means being able to follow commands. It is not fully awake like you and I talking to each other.

53

Q. But do you understand what extubated and fully awake means?
A. **I think I do.**
Q. Okay. Do you know what being kept in an upright Fowler's position means? Do you understand what that means?
A. **You still haven't told me what a Fowler's position is.**
Q. It's seated. It's seated and it varies from 15 to 90 degrees.
A. **Okay.**
Q. You got it?
A. **Got it.**
Q. Okay. And you understand what supplemental oxygen is because you're familiar with it being used.
A. **Correct.**
Q. Okay. All right. These are various things that did not occur in this patient, to your knowledge, correct?
MR. JOHNSON: What things?
MR. LEDBETTER: Excuse me?
MR. JOHNSON: What things?
MR. LEDBETTER: I just went

54

through them.
MR. JOHNSON: Well, do it again.
MR. LEDBETTER: Extubated and fully awake.
BY MR. LEDBETTER:
Q. He was not extubated and fully awake, was he?
A. **According to what I understood. He was following commands, though.**
Q. He was not kept in an upright position, was he?
A. **Not in the recovery.**
Q. And you did not witness him being on supplemental oxygen in the recovery room, did you?
A. **I don't know whether he was or wasn't.**
Q. Okay. You're also aware that a patient can be sent to the ICU instead of the PACU at LeBonheur, if you had ordered it? You're aware that that's possible?
A. **Yeah. That's conceivable, unlikely, yeah.**
Q. Okay.

55

A. **Though all the monitoring done in the ICU is the same monitoring they do in the recovery room.**
MR. JOHNSON: In ICU.
A. **It's the same monitoring either place.**
BY MR. LEDBETTER:
Q. But they are physicians instead of nurses and that does make a difference. Otherwise, we would have nurses open --
A. **No. The physician is not the person monitoring. It's the nurse.**
Q. So what you're saying is there was no reason to or no need to send him to ICU until he coded?
A. Correct.
Q. Okay. Now, were you aware on 3-12-2012 that the proper post-op position for a tonsillectomy is the lateral prone with the head to one side?
A. **That is the preferred position.**
Q. Okay. And would you agree that on 3-12-2012, that a patient with sleep apnea should avoid intraoperative opiates, but where given, should be completely awake with intact reflexes

56

and normal ventilatory patterns before extubation?
MR. GILMORE: Objection.
A. **Read the question again.**
BY MR. LEDBETTER:
Q. Were you aware that on March 12, 2012, that patients with sleep apnea should avoid intraoperative opiates?
MR. GILMORE: Same objection.
A. **No.**
BY MR. LEDBETTER:
Q. Were you aware that the same patients should be completely awake with intact reflexes and normal breathing before they're extubated?
MR. GILMORE: Objection.
A. **Routinely with sleep apnea -- and I deal with a lot of adults with sleep apnea -- you extubate them and then you follow them with the monitors, the oxygen, the monitors, the EKG, the CO2 monitor, and most of them do just fine right then.**
Q. But you have them sitting up, do you not, or in a --
A. **No, they are not sitting up. No one**

is sitting up.
Q. They are in the lateral position?
A. Usually, the lateral position or laying down.
VIDEO SPECIALIST: We are off the record at 11:15.
(Brief break)
VIDEO SPECIALIST: We are back on the record at 11:21.
11:30:48 MR. LEDBETTER: Do we need to re-identify or are we okay?
VIDEO SPECIALIST: You're good.
MR. LEDBETTER: We just go on?
VIDEO SPECIALIST: Just go on.
11:30:51 BY MR. LEDBETTER:
Q. Dr. Clemons, I don't mean to put myself back in reverse and go back and continue to beat something to death, but I just have a series of questions that should be fairly simple
11:31:17 to answer. In your op note, are there any late entries in it, to your knowledge? In other words, any entries that would not have been made in the first draft?
A. Not to my knowledge.

Q. Are you aware that the JCAHO requires that late entries must indicate that they are by a late entry?
A. What do you consider a late entry?
11:31:36 Hang on. Hang on. When you look at an op note, you're supposed to review it before you signed it --
Q. Right.
A. -- to make sure it is correct.
11:31:45 Q. And so what you are saying is that "itself" is not a late entry?
A. That would be my concern because when you dictate --
Q. Your interpretation.
11:31:53 A. -- it, sometimes there is misspellings or other things that you can't correct until you review it.
Q. Okay. But if you then sign it and go back and change it, you think that would be a
11:32:08 late entry?
A. Correct.
Q. Okay. Now, with respect to the decision to send Brett Lovelace to the PACU or the ICU, do you agree that that would have been a

choice that you had yourself? You had that choice?
A. It's extremely rare to send someone from the operating room to the ICU.
11:32:30 Q. But do you agree that the choice was yours?
A. I would have had to call the ICU attending and talk to him and explain to him why I wanted to send a patient up there, and he would
11:32:40 have to accept it.
Q. Again, my question is, the choice would have been yours to do?
A. Correct.
Q. And with respect to choosing an
11:32:52 anesthesiologist who had no record of suits, you had a right to ask for an anesthesiologist who has no previous record of malpractice suits, didn't you?
MR. GILMORE: Objection.
11:33:05 A. I didn't know I had that right.
BY MR. LEDBETTER:
Q. Okay.
A. I call up and ask for a -- schedule a case and the department decides who my anesthesia

is.
Q. You had a right to choose not to allow the anesthesia medications, one or more of them that were given, did you not?
11:33:21 A. I don't tell anesthesia how to do their job because I don't know how to do their job.
Q. Had you ever done any research to determine the safety and efficacy of Propofol and
11:33:36 Fentanyl as anesthetic agents?
A. No.
Q. And were you aware that at the time he was anesthetized, that he had some upper respiratory compromise going on at the time the
11:33:57 surgery began?
A. When he was asleep, he had a good airway. He was breathing very well.
Q. Are you aware that you had a right to choose the use of supplemental oxygen in the PACU
11:34:16 had you wanted to choose or specify that?
A. Supplemental oxygen is on the list of orders that I -- is on the lists of orders, correct.
Q. Okay. I don't see it on the list of

61

orders for the PACU, so I'm asking you if you had a right to choose supplemental oxygen?
A. It's an order that I could do.
Q. Okay. And you agree that you had a right to choose whether he was -- whether Brett Lovelace was in the lateral or the Sims' or the Fowler's position in the PACU, had a right to specify those positions as his surgeon, correct?
A. I could have ordered positions, but leave it to the ICU (sic) nurses because the patients tend to be moving around.
Q. Do you agree that you had a right to choose to read before the surgery and to learn any information about the narcotics and opiates that were used with Brett, but chose not to read about them?
A. I did not choose not to read about them.
Q. But you didn't choose to read about them, did you?
A. I did not make any -- I did not look up these drugs to see how they had this effect.
Q. And was one of the indications, I guess, is the term for the surgery, the T&A

62

procedure, the fact that Brett Lovelace had what has been referred to as sleep-deprived breathing?
A. Sleep-deprived breathing, I've not heard that term.
Q. It's in a 2011 clinical guideline for ENT physicians, isn't it?
A. Referred to his upper airway -- upper airway obstructions. Sleep-deprived breathing.
Q. Have you ever read the clinical guideline for ENT surgeons for tonsillectomies that came out in 2011?
A. Not that particular guideline.
Q. Now, in your -- in Exhibit Number 2, it says toward the bottom for tonsillectomy and adenoidectomy, discussed the risk of anesthesia. Did you specifically discuss with the parents the fact that Brett would be given Fentanyl and Propofol?
A. What I tell the families are there is always a potential risk from anesthesia. Not knowing what drugs the patient is going to get, I can't go into that kind of detail.
Q. Okay. Now, in July of 2013, I served upon your attorneys requests for admissions and I

63

did not get an answer or objection to these until December of 2013, over five months later. Are you aware of that?
A. No.
Q. Okay. Can you tell me why neither you or your attorneys took five months to respond to requests for admission that were submitted to you by Plaintiff on July 3, 2013?
A. I have no idea.
Q. Can you tell me whether or not you ever received for your signature, before December of 2013, a set of responses to sign to my requests for admissions that were sent to you?
A. I don't know.
MR. JOHNSON: Objection. You're misstating what's required of a response to a request for admission.
MR. LEDBETTER: That's all. I want to make these exhibits. I would also like to make Exhibit 4 the late provided CV of Dr. Clemons.
(WHEREUPON, THE ABOVE-MENTIONED

64

DOCUMENT WAS MARKED AS EXHIBIT NO. 4 TO THE TESTIMONY OF THE WITNESS AND IS ATTACHED HERETO.)
MS. MCGEE: This actually was the same one that was provided previously to you with discovery; however, as a courtesy to you --
MR. LEDBETTER: I didn't have it.
MS. MCGEE: -- as a courtesy to you, I brought it today.
MR. LEDBETTER: I stand corrected, but I didn't have it.
MR. JOHNSON: Well, it wasn't late provided. It was provided earlier, but it was supplementally provided today because we knew you would show up without it. How's that?
MR. LEDBETTER: Thank you.
MR. JOHNSON: Okay. Now, let me ask --
MR. LEDBETTER: I'm glad you are demonstrating prudence.

MR. JOHNSON: Let me ask Dr. Clemons --

CROSS-EXAMINATION

BY MR. JOHNSON:

Q. Dr. Clemons, you were asked some questions about who assigns anesthesia when you schedule surgery and it sounded like that y'all were talking over each other, and I'm not sure we cleared that up. When you or your office schedules surgery, who schedules the anesthesiologist or anesthesia?

A. **I suspect the anesthesia department itself decides who is going to do which cases depending on needs and skills.**

Q. Okay. So that's not something, though, that you, Dr. Clemons, take upon yourself to go and decide who is going to be administering anesthesia; is that true?

A. No.

Q. Is that true?

A. That's true.

Q. Thank you.

MR. GILMORE: No questions.

MR. LEDBETTER: No more

questions.

VIDEO SPECIALIST: This is the end of Tape 2 of two tapes. Counsel did waive the formal reading of the caption. We are off the record at 11:32.

(WHEREUPON, THE DEPOSITION WAS CONCLUDED AT APPROXIMATELY 11:40 A.M. AND FURTHER DEPONENT SAITH NOT.)

(SIGNATURE NOT WAIVED.)

ERRATA SHEET

I, the undersigned, _____, do hereby certify that I have read the foregoing deposition, and that to the best of my knowledge, said deposition is true and accurate with the exception of the following corrections listed below:

Page No.	Line No.	Correction
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____
(Deponent)

_____
(Date)

SWORN TO AND SUBSCRIBED before me, this ____ day of _____, 2014.

_____
Notary Public

My Commission Expires:

_____

CERTIFICATE

STATE OF TENNESSEE:
COUNTY OF SHELBY:

I, PEPPER GLENN, Court Reporter and Notary Public, Shelby County, Tennessee, CERTIFY:

The foregoing proceedings were taken before me at the time and place stated in the foregoing styled cause with the appearances as noted.

Being a Court Reporter, I then reported the proceeding in Stenotype, and the foregoing pages contain a true and correct transcript of my said Stenotype notes then and there taken.

I am not in the employ of and am not related to any of the parties or their counsel, and I have no interest in the matter involved.

I further certify that in order for this document to be considered a true and correct copy, it must bear my original signature and that any reproduction in whole or in part of this document is not authorized and not to be considered authentic.

Witness my signature this the ___ day of _____, 2014.

_____
PEPPER GLENN, CCR

Notary Public at Large
For the State of Tennessee
My Commission Expires:
October 18, 2014